

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 650

CERTIFICATE OF DEATH

Reg. Dist. No. 1439550

1. PLACE OF DEATH:

County Washington

City or town Berlin RFD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Berlin RFD
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Norman Noah Adkins

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

8.(b) Name of husband or wife Dorothy Adkins

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1886

8. AGE: Years 60 Months 8 Days 19 It less than one day _____ hrs. _____ min.

9. Birthplace Snow Hill Wm Co. Md
(Town, county, and state)

10. Usual occupation Bus Driver

11. Industry or business

12. Name J. Thomas Adkins

13. Birthplace Maryland

14. Maiden name Maggie Pennerwell

15. Birthplace Maryland

16. Informant Mrs. Norman N. Adkins

Address Berlin, Md

17. Burial Date thereof 11/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Dana B. Burboze

Address Berlin Md

19. 11-16 19 46 Belmont Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Nov 19 46 at 11:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Nov 19 46 to 13 Nov 19 46 and that I last saw him alive on 13 Nov 19 46

Immediate cause of death Central Hemorrhage

DURATION 3 days

Due to hypertension

2415

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Nathaniel Thomas MD
M. D. or other

Address Ocean City MD Date signed 14 Nov 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 19 1946
BUREAU OF

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 3500

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 83 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sallie A. Angelo.

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife John C. Angelo.
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 15-1863
8. AGE: Years 83 Months 4 Days 2 If less than one day
hrs. min.

9. Birthplace Pocomoke Worcester Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name William Richardson
13. Birthplace Maryland
14. Maiden name Mary Curtis
15. Birthplace Maryland

16. Informant Mr Thomas Angelo
Address Pocomoke Md
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov 19, 1946
(month) (day) (year)
Cemetery or crematory Halls Hill Baptist Ch
Location Pocomoke City Md
18. Funeral director Henry H. Dutton
Address Pocomoke City Md
19. Nov 18 19 46 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1946 at 6:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 1 19 46 to Nov 17 19 46
and that I last saw him alive on Nov 17 19 46
Immediate cause of death

	DURATION
<u>Renal Calculi</u>	<u>1 mo</u>
Due to	
<u>Sepsis</u>	<u>1 mo</u>
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

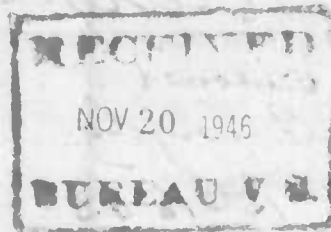
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Truman M. D. or other
Address Pocomoke Md Date signed 11-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11441 3530

1. PLACE OF DEATH:

County Worcester
 City or town Bishopville R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Bishopville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leander Gray

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Nettie J. Gray

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age _____ years
March 20, 1858

8. AGE:

Years

88

Months

7

Days

14

If less than one day

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

John Gray

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Leander Gray
Bishop, Md. R.F.D.

17. Burial, cremation, or removal, Which?

Burial

Date thereof

Nov 5, 1946
(month) (day) (year)

Cemetery or crematorium

Bishopville, Md.

18. Funeral director

M. Pasha Watson

Address

Bishopville, Md.

Nov 4 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 26 1946 to Nov 4 1946and that I last saw him alive on Nov 3 1946

Immediate cause of death

Cerebral thrombosis

DURATION

3 hrs.

Due to

Embolized Arterio Sclerosis - 5 yrs.

Due to

Other conditions

Carcinoma of Colon 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

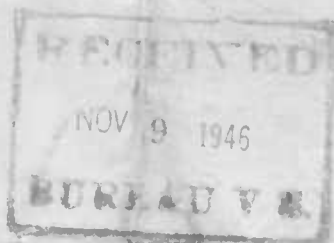
Injured at work?

23. SIGNATURE

Robert Long
Fram Woodall

M, D, or other

Date signed Nov 4, 1946



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8370

CERTIFICATE OF DEATH

Reg. Dist. No.

11448
265

1. PLACE OF DEATH: County..... Worcester City or town..... Snow Hill (If outside city or town limits, write RURAL and give nearest town) How long in above place of death..... 8 years Hospital, institution, or street address where death occurred: Gunby Street How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Maryland County..... Worcester City or town..... Snow Hill (If outside city or town limits, write RURAL and give nearest town) Street No..... Gunby Street (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME Kittie Harris				3. (b) Social Security Number			
4. Sex Female		5. Color or race Colored		6.(a) Single, married, widowed, or divorced Married		MEDICAL CERTIFICATION	
8.(b) Name of husband or wife William Harris				20. DATE OF DEATH..... 8 Nov 1946 at 12:29P.M.			
7. Birth date of deceased (mo., day, yr.) May 7, 1899				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Oct 1946 to 8 Nov 1946 and that I last saw him alive on 8 Nov 1946			
8. AGE: Years 47		Months 6n		Day 6		Immediate cause of death Cerebral Hemorrhage	
9. Birthplace New Bern, North Carolina		10. Usual occupation Canning factory work		11. Industry or business Vegetable canning		DURATION 1 1/2 days	
12. Name Abraham Lawfley		13. Birthplace North Carolina		14. Maiden name Unknown		Due to.....	
15. Birthplace Unknown		16. Informant William Harris		17. Burial, cremation, or removal. Which? Burial		Due to.....	
18. Funeral director H. Harvey Bradshaw		19. Date thereof Nov. 12, 1946		20. Cemetery or crematory Baptist Cemetery		Other conditions.....	
21. Address Snow Hill, Maryland		22. Address Pocomoke City, Md.		23. Address H/1/1/46		Major findings of operations.....	
24. Address Agatha E. Franklin		25. Address H/1/1/46		26. Address H/1/1/46		Autopsy results.....	
27. Address H/1/1/46		28. Address H/1/1/46		29. Address H/1/1/46		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
30. Address H/1/1/46		31. Address H/1/1/46		32. Address H/1/1/46		22. VIOLENCE: If death was due to external causes, fill in the following:	
33. Address H/1/1/46		34. Address H/1/1/46		35. Address H/1/1/46		Accident, suicide, or homicide.....	
36. Address H/1/1/46		37. Address H/1/1/46		38. Address H/1/1/46		Where did injury occur?.....	
39. Address H/1/1/46		40. Address H/1/1/46		41. Address H/1/1/46		Injured at home, farm, industry, public place (where?).....	
42. Address H/1/1/46		43. Address H/1/1/46		44. Address H/1/1/46		Means of injury.....	
45. Address H/1/1/46		46. Address H/1/1/46		47. Address H/1/1/46		Injured at work?	
48. Address H/1/1/46		49. Address H/1/1/46		50. Address H/1/1/46		23. SIGNATURE.....	
51. Address H/1/1/46		52. Address H/1/1/46		53. Address H/1/1/46		M. D. or other	
54. Address H/1/1/46		55. Address H/1/1/46		56. Address H/1/1/46		Address.....	
57. Address H/1/1/46		58. Address H/1/1/46		59. Address H/1/1/46		Date signed.....	
60. Address H/1/1/46		61. Address H/1/1/46		62. Address H/1/1/46		63. Address H/1/1/46	



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 3550

1. PLACE OF DEATH:

County Worcester
 City or town Ocean City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Wor.
 City or town Ocean City
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Isaac Hudson.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Elma J. Hudson6. (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) Aug. 28, 1880

8. AGE: Years 66 Months 2 Days 24 hrs. min.

9. Birthplace Berlin md RFD.
(Town, county, and state)10. Usual occupation Captain (Retired)11. Industry or business U.S. Coast Guard12. Name William I Hudson13. Birthplace Maryland14. Maiden name Sarah Baker15. Birthplace md.16. Informant Mrs. W. I. TurnerAddress Ocean City md17. (Burial, cremation, or removal. Which?) B. Date thereof 11/27/46
(month) (day) (year)Cemetery or crematory EvergreenLocation Berlin md.18. Funeral director Anna R. BurbageAddress Berlin md.19. 11-25 46 Elma J. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1946, at 11:20 AM21. I CERTIFY that death occurred on the date above elated; that I attended deceased from Sept 1946 to Nov 1946.
and that I last saw him alive on 22 Nov 1946.

Immediate cause of death Congestive Heart Failure - Myocardial Degeneration
 Due to Hypertensive Cardio Vascular Disease
 DURATION 3 months
9 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elma J. HaywardAddress Ocean City mdDate signed 11-29-46

RECEIVED
NOV 29 1946
BUREAU V.S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 120-01

CERTIFICATE OF DEATH

Reg. Dist. No. 11444 3500

1. PLACE OF DEATH

County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

William S. Lassiter

3. (b) Social Security Number

212-16-7462

4. Sex Male 5. Color or race Color 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Ollie Jane Lassiter
6.(c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) Sept 1, 1896
8. AGE: Years 50 Months 2 Days 9 If less than one day — hrs. — min.

9. Birthplace Severn North Carolina
(Town, county, and state)
10. Usual occupation Farming
11. Industry or business —
12. Name John Ray Lassiter
13. Birthplace N.C.
14. Maiden name unknown
15. Birthplace —

16. Informant Lillie Mae Collins
Address 1317 N 12th St Phila Pa
17. Burial Date thereof Nov 15, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Shelle Hill Cemetery
Location Rural Pocomoke Md
18. Funeral director Henry B. Watson
Address Pocomoke Md
19. Nov 15 19 46 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 19 46 at 10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 19 46 to Nov 10 19 46 and that I last saw him alive on Nov 10 19 46
Immediate cause of death Acute Enteritis
DURATION 24 hrs.

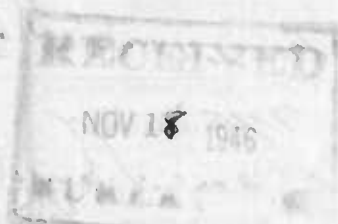
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings of operations None Date of op. —
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —
23. SIGNATURE Louis L. Davelyn MD
Address Pocomoke City M. D. of other —
Date signed 10-16-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 3570

11445

1. PLACE OF DEATH: Worcester
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 68 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Worcester
 City or town..... Griddlestone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war..... 70

3. (a) FULL NAME George L. Tarr Sr
 4. Sex Male 5. Color of race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Clara M. Tarr
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Sept. 19 - 1878

3. (b) Social Security Number
220-12-1091

8. AGE: Years 68 Months 2 Days 9 If less than one day..... hrs. min.

9. Birthplace Griddlestone Worcester MD
 (Town, county, and state)

10. Usual occupation..... Retiree

11. Industry or business Shipyard, Bay

12. Name Williams Tarr

13. Birthplace Maryland

14. Maiden name Harriet Stinger

15. Birthplace Maryland

16. Informant M. Guadalupe Tarr

Address Berlin, MD

17. Funeral Date thereof Dec 1/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Springfield

Location Griddlestone

18. Funeral director Gray & Dennis

Address Snook Hill MD

19. 11/30/46 Le Roy Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 19 46, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 46 to Dec 28 19 46
 and that I last saw him alive on 2 P.M. 19 46

Immediate cause of death Myocardial Infarction
Central Hemorrhage

Due to..... Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE Heaman L. L. L.
 M. D. or other

Address Berlin, MD Date signed 30 Dec 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 2 1946

OFFICE OF THE
ATTORNEY GENERAL

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3500

1. PLACE OF DEATH:

County Worcester
 City or town Rural Pocumoke Md.
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 62 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Rural Pocumoke Md.
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (if rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Isaiah A. Waters

3. (b) Social Security Number

4. Sex Male 5. Color or race Color 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lucia B. Waters
 8. (c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) July 19, 1884
 8. AGE: Years 62 Months 4 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Pocomoke, Worcester Md.
 (Town, county, and state)

10. Usual occupation Farming

11. Industry or business William R. Waters

12. Name William R. Waters

13. Birthplace Md.

14. Maiden name Laura Douglas

15. Birthplace Md.

16. Informant Lucia B. Waters

Address Rural Pocumoke Md.

17. Burial Date thereof Dec 3, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Unionville Cemetery

Location Rural Pocumoke Md.

18. Funeral director Shury & McDaniels

Address Pocomoke City Md.

19. Dec 2, 1946 Adne H. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1946, 2:05: P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 1946, to Nov 28, 1946, and that I last saw him alive on Nov 28, 1946

Immediate cause of death Gastric Carcinoma DURATION 1 yr.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis S. Cleveland, M.D. M. D. or other _____

Address Pocomoke City Date signed 11-30-46

RECEIVED

DEC 4 1946

BUREAU 78

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 11447 3540

1. PLACE OF DEATH:

County... Worcester
 City or town... Stockton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md County... Worcester
 City or town... Stockton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... none
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Lelia Frances Wilson

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Frank Wilson 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 Months - Days - If less than one day _____ hrs. _____ min.

9. Birthplace Stockton-Worcester-Maryland
 (Town, county, and state)
 10. Usual occupation Widwife

11. Industry or business _____

12. Name Alfred Bennett

13. Birthplace Stockton, Maryland

14. Maiden name Mary Ann Collins

15. Birthplace Stockton, Maryland

16. Informant Irving Bennett

Address Stockton, Md.

17. Burial (Burial, cremation, or removal. Write) Date thereof 11-18-1946
 (month) (day) (year)
 Cemetery or crematory Methodist Cemetery

Location Stockton Md.

18. Funeral director Irving Bennett

Address Stockton, Md.

19. Nov. 17 19 46 Mary M. Taylor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 19 46 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 19 45 to Nov. 15 19 46.
 and that I last saw him alive on Nov. 14 19 46.

Immediate cause of death Respiratory paralysis. DURATION 24 hours

Due to Cerebral Vascular Accident. 2 days

Due to Hypoglycemic Coma 10 yrs.
Renal Syndrome

Other conditions Diabetes Mellitus.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE I. Bennett M. D. or other _____
 Address Grand Hill Date signed 11-18-46

RECEIVED
DEC 5 1946
BUREAU

2-35